



Faith Equestrian Therapeutic Center

912-728-3728 / 912-655-1480

Cover letter

Thank you for your interest in Faith Equestrian Therapeutic Center (FETC) The first step toward participating in a FETC program is to complete and return the necessary forms.

Before a participant can be considered for inclusion in the Faith Equestrian Therapeutic Center programs the attached forms must be completed and returned to FETC.

- > New and present participants must meet the FETC age and weight policy as stated on attached "Policies" sheet (keep the policies for your records)
- > Physician's cover letter and medical history & physician's statement must be completely filled out and signed by the participant's physician
- > Participant's Authorization for Emergency Medical Treatment to be completed
- > Participant's registration and photo release form completed
- > Risk waiver / release signed by parent or guardian

Once all forms are received at Faith Equestrian Therapeutic Center and are verified for completeness, and we are notified of acceptance in an assistance program, refused, or haven't applied, an evaluation will be arranged. During the evaluation, we will ensure that our program is appropriate for the potential participant and that there are no contraindications to participation in horseback riding activities. We will also discuss other assistance sponsorships (if you have been refused assistance or have not applied) A brief mounted evaluation will take place if appropriate. Spaces are reserved on a first come first serve basis.

FETC strives to provide the safest possible conditions for participants, volunteers, employees and horses. The acceptance and continued participation of a participant in our program depends on the availability of instructors, volunteers and suitable horses, and is based on our determination that we can safely accommodate the participant. FETC adheres to precautions and contraindications for participants established by the Professional Association of Therapeutic Horsemanship Intl (PATH). FETC retains the right to refuse any participant that we cannot safely accommodate. Participants must inform FETC of changes in their health status and an annual update of the Medical History Form and Physician's Form is required.

FETC offers week day classes (On availability of volunteers) and Saturday sessions.

The Winter / Spring session will run from Jan, March, April, May, 16 weeks.

The Fall session will run from September, November, 2012, 13 weeks

Tuition cost is \$25 which will be absorbed by special assistance, sponsorships or scholarships. It is recommended that you apply for assistance as part of the application process, but remember, we will help you find assistance or sponsorships if you are refused by an assistance program that you apply to, and we will help you fill out all forms if needed. If there is no assistance you fee will be \$15.00 per class.

We thank you for your interest and look forward to serving you soon. Please feel free to contact the office if you have any questions at (912) 728-3728 or (912)-655-1480 Monday through Friday 9am -5pm

Sincerely,

Bonnie Gentry / Program Director



Faith Equestrian Therapeutic Center
(912) 728-3728 / (912) 655-1480

Authorization of Emergency Medical Treatment Form

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Faith Equestrian Therapeutic Center to Secure and retain medical treatment and transportation if needed. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Participant Name:	Phone:	Phone:
Address:	City:	State / Zip:
if I cannot be reached Contact:	Phone:	Phone:
Alternate Emergency Contact:	Phone:	Phone:
Physician's Name:	Phone:	
Preferred Medical Facility:		
Health Insurance Company:	Policy*:	

Consent Plan

The authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Consent Signature: (Client, Parent or Guardian):	Date:
Please Print Name:	Phone*:

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services, or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Consent Signature: (Client, Parent or Guardian):	Date:
Please Print Name:	Phone*:



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POLICIES

(KEEP THIS WITH YOUR RECORDS)

Unfortunately, riding is not an appropriate activity for everybody and we occasionally have to decline services to those to whom riding is contraindicated. As a PATH Professional Association of Therapeutic Horsemanship Intl program, we must follow PATH guidelines. To be in compliance with PATH national standards, we have established the following:

Session Assistance Policy

For riders to participate in the program it is recommended that you make application to Easter Seals or another assistance program for the tuition fees at the time you apply to us. We will help you fill out all forms. If you are disapproved for assistance we can still accept your child in the program with a sponsor which we will help to provide.

Age Policy

Minimum Age: 4 years old for therapeutic riding lessons

Maximum Age: There is not a maximum age. The only requirement is that the person is able to physically and safely perform what is required in a therapeutic riding lesson.

Weight Policy

According to PATH guidelines, riding is contraindicated:

1. If the staff is unable to safely manage the participant in any situation, including an emergency dismount.
2. If safety or comfort of the horse is compromised during mounted activities.
3. **Maximum Weight Limit:** 175lbs. However, certain factors such as cognitive skills and the balance of the rider are taken into account at the time of assessment. Riders will be evaluated by staff to determine if riding is a safe and appropriate activity.

Absence Policy

- ❖ Classes are held weather permitting- if it is raining or rain is imminent- or if the day time temperature is below 40 degrees classes will be postponed until the next weeks class.
- ❖ If a rider is absent, there is no make-up class. Make-up classes are scheduled only when FETC cancels a class for reasons other than weather.
- ❖ Because a number of volunteers commit their time to ensure a safe ride, we request 24 hours notice when a rider knows they will be absent. Please contact the class coordinator or instructor directly.
- ❖ 3 absences without notice will result in cancellation of the rest of the session and registration for the following session will be disregarded.



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Client Medical History & Physicians' Statement

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Participant Name:	Date of Birth:	Age:	Sex:	Race:	Height:	Weight:
Name / Address of Guardian:				Tetanus Shot: YES NO		
Diagnosis:				Date of Onset:		
Medications:						

Please indicate if patient has a problem and/or surgical history in any of the following areas:

AREA	YES	NO	COMMENTS	AREA	YES	NO	COMMENTS
Auditory				Muscular			
Visual				Independent Ambulation			
Speech				Crutches			
Allergies				Braces			
Cardiac				Wheelchair			
Circulatory				Neurological			
Learning Disability				Orthopedic			
Mental Impairment				Pulmonary			
Psychological Impairment				Other			
Seizures			Type:	Controlled:			Date of Last Seizure:

** Please complete required information on page 2 for SEIZURE patients ** See Page 2 for list of precautions and contraindications

ATLANTO - AXIAL INSTABILITY ASSESSMENT FOR PATIENTS WITH DOWN SYNDROME

If the patient has Down syndrome a full radiological examination establishing the absence of Atlanto-axial Instability is REQUIRED before they may participate in equestrian activities which, by their nature, may result in hyperextension, radical flexion or direct pressure on the neck or upper spine. Yes No

Has an x-ray evaluation for atlanto-axial instability been done? DATE of X-RAY _____

If yes, was it positive for atlanto-axial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

If this X-Ray is more than 1 year old Please state the result of the most recent visual examination conducted within the past six months:

- The client has not had a timely physical examination and so cannot at this point be so certified.
- The client's annual physical examination reveals no symptoms of MI
- The client's annual physical examination shows symptoms of MI. Riding is CONTRAINDICATED.

I have reviewed the attached list of conditions which may present precautions and contraindications to therapeutic horseback riding on page 2, to my knowledge there is no reason why this person cannot participate in supervised equestrian activities:

Physician's Signature:	Date of EXAM:
Physician's Name (please print):	Physician's Phone:
Address:	Physician's FAX:



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Client Medical History & Physicians' Statement
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SEIZURE DISORDER PARTICIPANTS -----(write N/A if child does not have seizures)

PATH (Professional Association of Therapeutic Horsemanship Intl) recommends the following information for PATH operating Centers for riders with seizure disorders.

Would you consider _____'s seizures to be:

- Completely controlled Very well controlled Fairly controlled by medication

Type of seizure:	
Typical aura:	
Typical motor activity during seizure:	
Description of clients behavior during post-ictal state:	post-ictal state duration:
Specific directions as to what to do if a seizure should occur at Faith Equestrian Therapeutic Center:	
Physicians signature	Date:

INFORMATION FOR PHYSICIAN

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present and, if so, to what degree.

ORTHOPEDIC

Spinal Fusion
Spinal Instabilities/Abnormalities
Alantoaxial Instabilities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation and Dislocation
Osteoporosis
Pathologic Fractures
Coxas Arthrosis
Heterotopic Ossification
Osteogenesis Imperfecta
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization
Disease

NEUROLOGIC

Hydorcephalus/shunt
Spina bifida
Tethered Cord
Chiari I Malformation
Hydromyelia
Paralysis due to Spinal Cord
Injury
Seizure Disorders

SECONDARY CONCERNS

Behavior Problems
Age under 2 years
Age 2 - 4 years
Acute exacerbation of Chronic disorder
Indwelling catheter

MEDICAL / SURGICAL

Allergies
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Serious Heart Condition
Stroke (Cerebrovascular Accident)



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PARTICIPANT REGISTRATION AND PHOTO RELEASE

PARTICIPANT NAME:	DATE OF BIRTH:	AGE:	SEX: M F
ADDRESS:	CITY:	STATE / ZIP	
Home phone:	Cell phone:	E-mail	
Parent (custodial) or Guardian:	Address if different:	Phone if different:	
School or programs presently attending:			
Please describe any previous experience with horses / riding (no experience is required):			

I would like to register for the following session (s) in 2012:

Winter / Spring (Jan, March, April, May) Fall (Sept., Oct., Nov.)

Photo release (YOU MUST CHECK ONE BELOW) do not leave blank

- I do consent
- I do not consent

to and authorize the use and reproduction by Faith Equestrian Therapeutic Center of any and all photographs and any other audio-visual materials taken of me / my child for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Please sign below only if you checked "I do consent"

Date: _____ Signature: _____ client, parent/guardian



Faith Equestrian Therapeutic Center

(912)728-3728

GENERAL ACTIVITY RELEASE, ASSUMPTION OF RISK and WAIVER OF LIABILITY AGREEMENT

This document waives important legal rights. Read it carefully before signing.

I AGREE for my child, and/or administrators, my /our assigns, in consideration for my, and/or my child's, and myself participation in Faith Equestrian Therapeutic Center activity of the following:

I AGREE that I choose to participate voluntarily in Faith Equestrian Therapeutic Center activities as a rider, handler or spectator. I am fully aware and acknowledge that horse sports and Faith Equestrian Therapeutic Center activities involve inherent dangerous risks of accident, loss, and serious bodily injury including, but not limited to, broken bones, head injuries, trauma, pain, suffering or death ("Harm"). I fully understand that this release covers, but is not limited to, inherent risks of an equine activity, which mean a danger, or condition that is an integral part of an equine activity, including but not limited to, any of the following:

- ❖ **The propensity of an equine to behave in ways that may result in injury, death, or loss to persons on or around the equine;**
- ❖ **The unpredictability of an equine's reaction to sounds, sudden movement, unfamiliar objects, persons, or other animals;**
- ❖ **Hazards, including, but not limited to, surface or subsurface conditions;**
- ❖ **A collision with another equine, another animal, a person, or an object;**
- ❖ **The potential of an equine activity participant to act in a negligent manner that may contribute to injury, death, or loss to the person of the participant or to other persons, including but not limited to, failing to maintain control over an equine or failing to act within the ability of the participant.**

I AGREE that I/my child/my ward would like to participate in the Faith Equestrian Therapeutic Center program. I acknowledge the risks and potential risks; however, I feel that the possible benefits to me / my child / my ward are greater than the risk assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors or administrators waive and release forever all claims for damages against Faith Equestrian Therapeutic Center, it's Board of Directors, instructors, therapists, aides, volunteers, employees, Twin Pines Farm, and affiliated organizations for any and all injuries and/or losses I may sustain while participating in the Faith Equestrian Therapeutic Center program including activities occurring outside of the scope of the program itself, including, but not limited to transportation, care giving, horse exercising etc.

By signing below, I ACKNOWLEDGE that I enter into this release after having read the same, and place my signature hereto of my own free voluntary act and deed. By signing below, I represent to Faith Equestrian Therapeutic Center that I fully understand its contents, that I do not need any further explanation, and I waive any further explanation.

I AGREE to assume all risks of Harm to me and / or my child, and specifically agree to the GEROGIA LIABILITY LAW regarding equine / farm **animal activity liability: Under Georgia Law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in an equine activity resulting from an inherent risk of equine activity, chapter 12, Title 4 of the official code of Georgia annotated. ACCEPTED BY: (if under the age of 17 years old, there must be a legal guardian signature below)**

PARTICIPANT Signature / Legal Guardian Signature(s):	VOLUNTEER Signature / Legal Guardian Signature(s):
Print Participant Name / Legal Guardian Name(s): DATE:	Print Volunteer NAME / Legal Guardian NAME(S): DATE: